MEETING AGENDA

Wednesday, April 24, 2019
2:30 p.m. – 4:30 p.m.

Call to Order

Welcome/Introductions

Approval of Agenda

Approval of Minutes

Report of Co-Chairs

Report of Staff

Prevention Services Initiatives

Discussion Items:

- PrEP Workgroup Report (continued)
- UCHAPS Letter

Old Business

New Business

Announcements

Adjournment

PREVENTION COMMITTEE

Please contact the office at least 5 days in advance if you require special assistance.

The next Prevention Committee meeting will be held on
Wednesday, May 22, 2019 from 2:30 - 4:30 p.m. at the
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Philadelphia HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, March 27, 2019
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Katelyn Baron, Keith Carter, Gus Grannan, Lorett Matus, Eran Sargent, Clint Steib, Erica Rand

Excused: None.

Absent: Nhakia Outland

Guests: Luis Noquera

Staff: Nicole Johns, Briana Morgan, Dustin Fitzpatrick

Call to Order: C. Steib called the meeting to order at 2:38 p.m.

Welcome/Moment of Silence/Introductions: C. Steib welcomed Prevention Committee members and guests.

Approval of Agenda: C. Steib presented the agenda for approval. **Motion** K. Carter moved, E. Rand seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes *(February 27, 2019)*: C. Steib presented the minutes for approval. **Motion**: E. Sargent moved, K. Baron seconded to approve the February 27, 2019 minutes. **Motion passed**: All in favor.

Report of Co-Chair:
None.

Report of Staff:
N. Johns informed members of the listening sessions in Delaware and Bucks Counties on April 10th and April 30th, respectively. These are facilitated community conversations specifically for people living with HIV and other members of the community, asking about access to medical care and other essential services related to HIV treatment and prevention. Other locations throughout the EMA will have listening sessions throughout the year. She noted that there are Facebook events for members to share[1]. She asked the group to share any community-based locations as we move forward in planning future locations.

B. Morgan informed members of what was discussed at the New Jersey HPG meeting. She informed them that they learned that Salem County provides medical shuttles to

[1] Office of HIV Planning Facebook page with event information: https://www.facebook.com/hivphilly/

Philadelphia and Delaware medical providers for any county resident[2]. She said NJ is doing weekly meetings for End the Epidemic Plan and that they are hoping to present it to the governor by June. One of their targets is for 100% of people living with HIV to know their status and 95% of PLWH to reach viral suppression.

L. Matus asked if there were any reports back from the PA Counties. B. Morgan asked about there were questions around HIV testing and how that is happening in the suburban counties. There are other data questions from Comprehensive Planning so these requests will be together. There is also a plan to have a panel to talk about testing in the suburbs but that has been pushed back to review of Prep Work Group Report.

Discussion Items:

PrEP Workgroup Report

B. Morgan informed members that the final approved PrEP Workgroup Report was in their packets. She explained that they were going to try a new process to review the document with a worksheet. G. Grannan reminded members that it was a subgroup of the Prevention Committee and the way that they should take this is as a starting point with the work of developing a coordinated PrEP rollout in the EMA. He emphasized that they will hopefully continue to work with people who were going to the PrEP workgroup but not the Prevention Committee or HIPC. He stressed that there is a need for the same cultural competency that HIV prevention is known for. This report is an ongoing process and can be changed and adapted as they bring it into the EMA's integrated plan. B. Morgan reminded members about the history of the PrEP Workgroup. She explained that AACO did a lot of the organizing of the work of the workgroup and pulled together the report from discussions and comments from the workgroup. The workgroup was created as an ad hoc workgroup of the Prevention Committee in fall of 2017.The work plan takes strategies and activities from the EMA's integrated plan and adds additional data and context, as well as comments and discussions from the PrEP Workgroup. This document is approved by the PrEP Workgroup, and now it is here before the committee to edit, change, add to, etc. The committee is responsible to presenting to the HIPC for approval.

B. Morgan pointed the group to the worksheet created for feedback on the report. She asked the group to get into smaller groups of 2-3 people to review individual sections of the report and fill out the worksheet. The worksheet asks for highlights, what should be updated/changed, what should be added, what should be removed or clarified, and finally to note any typos.

K. Carter inquired about the deadline to the HIPC for approval. N. Johns stated its whenever the committee would like. B. Morgan stated that even though they are planning a general update in 2020, they can add the report to the integrated at any time, once its final.

Members broke into pairs and were assigned to look over specific pages of the report to discuss as a larger group. Members took 30 mins in small groups. Members then reviewed what they thought should be highlighted, updated, added, clarified, and

[2] More information: https://www.salemcountynj.gov/2019-scoot-shuttle-schedule/

correction. C. Steib clarified that the groups would be looking to the Discussion and Key Elements sections of each strategy to figure out what needs to added, changed, clarified, etc. The items which describes the activities or strategies, those are from the integrated plan and not for changing/discussion at this time.

C. Steib noted that he and L. Matus did pages 4-5. He stated that one highlight from page 5, under Key Elements should be that 12,000 of the 13,000 Philadelphians with indications for PrEP are not on PrEP. L. Matus noted they thought there should be more outreach about PrEP at health fairs and other community settings in the spring and summer. D. Gana noted that the AIDS Education month events there will be PrEP outreach and having the PDPH PrEP videos and other content broadcasted. L. Matus commented that the collar counties data about PrEP should be added. She noted that PrEP provider list is available but people do not know how to access that list or how to share it with the community. It is not accessible to all the communities and needs to be printed and available in multiple languages.

K. Carter and L. Noquera reviewed pages 6-7. K. Carter noted that the campaigns should be in multiple languages including Spanish and Asian languages. K. Carter also noted the Russian and Eastern European communities in the Northeast Philadelphia and suburbs. He said that there needs to be more information about PrEP in doctor's offices and laboratory sites. There should be brochures and posters in those places. He noted that information about how to get access to PrEP without insurance. He noted that women and trans men need to be included in the discussions about populations. K. Carter noted that he hasn't seen any of the public campaign in a language other than English. B. Morgan noted that the social media campaigns are targeted to people who interact in Spanish. K. Carter asked if the targeted social media campaigns are using the platforms young people use. B. Morgan noted that they are using Instagram and Twitter, as well as Facebook. E. Sargent noted that there is a hashtag #PhillyKeepOnLovin. K. Carter noted that the workgroup had a Dropbox folder with PrEP information and that should be more publicly available. B. Morgan noted that there may be a different way to share that information in the future. The Office of HIV Planning will be working on it. C. Steib noted that PDPH has PrEP and PEP posters. He noted that all PrEP providers should be notified that these posters are available. E. Sargent noted that providers can contact AACO to get marketing materials delivered to them like brochures, posters, flyers. There are plenty available. C. Steib that should be emphasized to providers. E. Sargent said that it was up to organizations to let AACO know when they run out of materials. B. Morgan that OHP can get materials for people to distribute as well.

E. Rand and J. Roderick reviewed pages 8 and 9. E. Rand noted that the social media and web traffic should be highlighted. She noted that Key Elements around PrEP Provider list should be included, how to get it. She noted that information about who is visiting PrEP Providers should be shared. Discussion areas to include that there should be emphasis on LQBT youth as a whole should be discussed and how PDPH are collaborating with youth serving organizations and advertising Do You Philly. She noted her agency did not have Do You Philly materials. G. Grannan noted that city prohibits agencies who are working

with injectors are not allowed to work with people under 18. There are youth injecting, as noted in Hepatitis C incidence.

E. Rand noted that navigation services are Club 15-09. She said the numbers around that should be highlighted. She noted that recruitment methods should be more specifically noted in Discussion. How do they reach populations to let them know Club 15-09 exists? E. Rand noted that it should clarify what is going to happen when Club 15-09 ends in a few months. She noted that this entire page becomes irrelevant once that program ends. E. Sargent noted that she is the Club 15-09 education coordinator. She agreed that the way the program has impacted the entire HIV prevention programs, including 18-02 grant and comprehensive prevention services overall. Club 15-09 brought social determinants into the conversation. L. Matus noted that testers are mostly referring people to the navigators and expressed concerns what will happen once the program ends. The group discussed the need for planning around what happens when the program ends. E. Sargent noted that the strategy and activities can be adjusted to talk about existing navigation programs, which may be in clinical settings rather than community-based settings. E. Sargent noted that the 15-09 grant was specifically for community-based organizations and the 18-02 grant the emphasis is in clinical settings for prevention services. She noted experiences in both settings. C. Steib noted that stronger collaboration between agencies need to happen as 15-09 ends. K. Baron noted that as clients get to know providers, the transition is really important for them to remain engaged. B. Morgan noted that 18-02 is the normal health department prevention grant from the CDC and 15-09 was a specific funding stream outside of that, as a pilot program. K. Baron noted that organizations may continue the programs from other funding streams. E. Sargent explained that there was a grantee meeting for 15-09 a few weeks ago. She noted that there was no official word that the program will be continued from the CDC. No more clients will be accepted at the end of the June and the program will continue until September. She noted that there is a lot unknown about the continuation of the program.

Members paused on page 9 and will continue to review the rest of the report next month. B. Morgan held onto members comments until next month.

The group discussed how some populations like people who inject drugs and sex workers are left out of campaigns for PrEP and other prevention programs. B. Morgan noted that programs/grants are tied to specific populations and communities, which can be restrictive.

Presentation Planning

B. Morgan reminded the group that K. Baron had provided some questions from UCHAPS on technical assistance needs from jurisdictions. OHP sent the survey to committee members which asked which kinds of TA needed and offered to other jurisdiction. B. Morgan noted that of the 5 responses all the topics were requested except for three. Some of the topics were also offered by committee members and others we have local experts that we could bring in. She asked the group for priorities of what they

want to learn about and specifically what they would like to learn about the topic. These requests can also be for the entire HIPC or a special presentation.

G. Grannan noted that some of the topics can be combined like Co-infections and Hep C. He noted that there may be natural subject areas. L. Matus noted that impact of mental health and HIV on each other is something she would like to learn more about. She also noted that she needed a better understanding of side effects of medications and effects of HIV. N. Johns noted that Dr. Short could include these types of questions into his medical update at the HIPC meeting in May.

E. Sargent noted that there have been new medications introduced over the last year or so. She asked what are the clinical indications of switching medications. She asked for that to be included in the medical update or something different. B. Morgan noted that this kind of things are the topics included in medical updates. C. Steib noted that injectables should be included in the conversation as well.

K. Carter noted that the HIPC needs to have more information about disparities: including racial, economic, geographic, and other types of disparities. G. Grannan noted that disparities can be considered intersectionally. N. Johns noted that a social determinant of health is a good place to start and then the other conversations can be layered in after that. She noted that the EMA has disparities around economics and insurance status, but not necessarily in terms of race in HIV outcomes. G. Grannan noted that this is different from general population health outcome disparities and noted that it could be an effect of the Ryan White system. D. Gana noted there are geographic difference in access to medical and other services, this is a disparity in the EMA as well. N. Johns that discussing disparities can start by focusing on intersections on HIV risk and social determinants. She noted that there are maps of social determinants at hivphilly.org for the counties in the EMA.

K. Carter commented that mental health and HIV should be a priority for the committee to discuss. How do mental health concerns impact HIV treatment and prevention? G. Grannan noted that often when dealing with substance use and mental health, providers can say that one of those need to be addressed before the other, and it changes between providers. He noted that he would be curious to hear if this kind of thing is happening in HIV and mental health providers. B. Morgan noted that OHP is working on having an expert present on mental health and HIV. She asked the group to refer speakers to OHP staff so we can invite them to present to the HIPC and committees.

Old Business:
None.

New Business:
None.

Announcements:

Thrivers, people who are long term survivors of HIV, giving a positive spin to living with HIV are a new group meeting monthly. They meet at St. Luke's Church.

April 19th – Second Anal Health Conference at Drexel University College of Medicine. Register through meetup.com

Abstracts for posters for the Prevention and Outreach Conference are due April 26th and should be submitted to fight.org

Adjournment: The meeting was adjourned by general consensus at 4:26 p.m.

Respectfully submitted by,

Nicole D. Johns, OHP Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from February 27, 2019
- PrEP Workgroup Report
- PrEP Document Feedback Worksheet
- Technical Assistance Results
- OHP Calendar

Service Priority Setting Worksheet 2019

Each service category will be scored according to these factors and scales using the sources noted for each factor. For the Community Voices factor each individual will vote their conscience (as informed by EMA data and committee deliberations) and the service category scores will be tallied by the average of those scores.

Factor	Definition	Scale
Consumer Survey (20%)	Percentage of consumers who said they used or "needed but didn't get" in the last 12 months, in the 2017 Consumer Survey. The sample is geographically representative of the EMA and includes PLWH who have engaged in the RW system.	1- no mention 3- >7.5% 5- 7.6-15% 8- 15.1%
Medical Monitoring Project (20%)	Medical Monitoring Project data captures unmet service needs for PLWH in care. It is a representative sample of PLWH in HIV care. The data sample if Philadelphia only.	1 – no mention 3 – > 14% 5 - 15-44% 8 – 45%
Client Services Unit-Need at Intake (20%)	Self-reported service need to Client Services MCM intake. These individuals are re-entering or entering the RW service system. The data sample is not EMA-wide- Philadelphia and PA counties with very few NJ.	1 – no mention 3 – >25% 5 – 26-51.6% 8 – 51.7%
Community Voices (40%)	This factor seeks to quantify community experience/expertise of delivering and receiving HIV services in relationship to emergent needs and issues, vulnerable populations, community knowledge, and other EMA data.	1- this service is important to ensure engagement in care, retention in care and/or viral suppression 5- This service is needed to ensure engagement in care, retention in care, and/or viral suppression 8- This service is critical to ensure engagement in care, retention in care and viral suppression.

UCHAPS

April 24, 2019

Dr. Eugene McCray, Director of Prevention Programs
Division of HIV/AIDS Prevention
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329-4027

Dear Dr. McCray:

UCHAPS is a national collaboration of community partners and health departments dedicated to preventing new HIV infections and reducing health disparities. UCHAPS jurisdictions have over 20 years of addressing issues with innovative local solutions based on strong partnerships and engagement with government and community stakeholders.

In light of the President's Ending the Epidemic Plan, we offer the following recommendations for successful end to the HIV epidemic.

1. **Support directly-funded jurisdictions**
How money reaches health departments is crucial and dedicates priorities. "Counties" are specifically referenced in all the materials and directly-funded localities are not since there are far more counties without directly-funded cities. However, should additional resources be made available in the future, these should flow through directly-funded cities. Where possible, provide flexible support to coordinate regional HIV prevention efforts beyond city limits.

2. **Host jurisdictional meetings**
CDC to hold a working meeting with representatives from the directly-funded jurisdictions and those from counties without directly funded cities to gather recommendations.

3. **Meaningfully involve community in planning activities**
Invite community to the table and include them in the planning so that they are meaningfully involved in ETE activities. Offer a space for organizations to articulate how they feel about the President's ETE rather them a call mostly dedicated to federal presentation. Silencing discussion and community engagement leads to poor health outcomes and increased HIV stigma.

4. Encourage affordable healthcare
A realistic, feasible and innovative plan to end the epidemic must address limited access to healthcare and encourage affordable healthcare.

5. Defend network of safety net programs
Collaborate with other federal agencies to offer safety net programs to the most vulnerable community members and discourage cuts to safety net programs such as SNAP, HOPWA and Medicaid that support HIV prevention efforts.

6. Support medical providers and comprehensive care
Funding cuts to medical agencies that provide a wide-range of legal medical services or policies such as gag order that interfere with the patient-physician relationship in the exam room are also of concern. Title X program ensures that every person — regardless of where they live, how much money they make, their background, or whether or not they have health insurance — has access to basic, preventive health care including STI testing, exams and treatment. Gag orders that restrict physicians and nurses from speaking with their patients about comprehensive medical care harm relationships that rely on honest and unfiltered discussions so that patients can make informed decisions about their health. Gag orders limit and potentially disrupt medical care.

7. Use culturally appropriate language
Insist on the use of culturally appropriate language for successful implementation in diverse communities and resist efforts to normalize racist and anti-immigrant rhetoric that further stigmatizes and derails HIV prevention efforts.

In Partnership,

Andre H. Ford, PhD
Board President

UCHAPS Co-Chairs:
W. Jeffrey Campbell
Government Co-Chair

Andrew McCarty
Community Co-Chair

UCHAPS Member Jurisdictions:
Baltimore, Maryland
Fulton County, Georgia
Chicago, Illinois
Houston, Texas
New York, New York
Philadelphia, Pennsylvania
San Francisco, California
Washington, District of Columbia